TREATMENT PLAN

Client's Name: ______________________ Date: ______________

Problem: ____

As evidenced by: ____

Long term goal: ____

Short Term Objectives: 1.) ________________________________

2.) ________________________________

3.) ________________________________

Problem: ____

As evidenced by: ____

Long term goal: ____

Short Term Objectives: 1.) ________________________________

2.) ________________________________

3.) ________________________________

Problem: ____

As evidenced by: ____

Long term goal: ____

Short Term Objectives: 1.) ________________________________

2.) ________________________________

3.) ________________________________

Therapist's signature: ______________________________ Date: ________

Client's signature: ________________________________ Date: ________

Client's signature: ________________________________ Date: ________

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